

Document: Summary Comparison of Medical Plans 2010	Document#: BEN-AE-007	Issue Date: 10/01/2009	Revision#: 000	Revision Date: 10/01/2009
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SUMMARY COMPARISON OF MEDICAL PLANS 2010

BENEFIT HIGHLIGHTS	CIGNA OPEN ACCESS PLUS		CIGNA NETWORK POS		HMO IL and BLUE ADVANTAGE HMO
	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK	OUT-OF-NETWORK	IN-NETWORK

CALENDAR YEAR PLAN DEDUCTIBLE

Individual	\$300	\$550	N/A	\$350	N/A
Family Maximum	\$900	\$1,650	N/A	\$1,050	N/A
	Deductibles accumulate in and out-of-network				

CALENDAR YEAR OUT-OF-POCKET MAXIMUM

Individual	\$1,500	\$3,000	Co-pays where applicable	\$3,000	\$1,500
Family Maximum	\$4,500	\$9,000	Co-pays where applicable	\$6,000	\$3,000
	Out-of-pocket max accumulate in and out-of-network Excludes Deductible & Co-Pays			Excludes Deductible	Excludes co-pays for Rx, vision, durable medical equipment & prosthetics
LIFETIME MAXIMUM - PER PERSON	\$2,000,000 - accumulation of in and out-of-network		Unlimited	\$2,000,000	Unlimited

DEPENDENT COVERAGE Unmarried dependents may be covered until age 26; Unmarried Military Veteran dependents may be covered until age 30 and must reside in Illinois.

PHYSICIAN CHARGES

Office Visits	\$20 Co-pay PCP, 100%	80% Subject to deductible	\$20 Co-pay, 100%	70% Subject to deductible	\$15 Co-pay, 100% PCP
	\$30 Co-pay Specialist		\$30 Co-pay Specialist		\$25 Co-pay Specialist
Hospital Visits	90% Subject to deductible	80% Subject to deductible	100%	70% Subject to deductible	100%
Chiropractor	\$30 Co-pay, 100%	80% Subject to deductible	\$30 Co-pay, 100%	70% Subject to deductible	\$25 Co-pay need referral from PCP

*PCP co-pay will apply to the following physician specialty types: internal medicine, general practitioner, family practice, pediatrician, optometrist, and obstetrician/gynecologist (OB/GYN). Under Cigna Open Access Plus and Point of Service Plan: if your OB/GYN provider is listed as a PCP in the provider directory, you will pay a PCP copayment. If your OB/GYN doctor is listed as a specialist, you will pay the specialist copayment. You do not need a referral to visit an OB/GYN provider.

DIAGNOSTIC X-RAY AND LAB TESTS

Billed by Dr. Office	\$20 Co-pay, 100%	80% Subject to deductible	100%	70% Subject to deductible	100%
Billed by Other Than Dr. Office	90% Subject to deductible	80% Subject to deductible	100%	70% Subject to deductible	100%

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HOSPITAL					
In-Patient	Pre-admission certification is required. Your in-network provider must call Member Services for approval or penalty applies.	Pre-admission certification is required. You must call Member Services for approval or penalty applies.	Primary care physician must approve hospital stay. \$200 co-pay (per admission), 100%.	Pre-admission certification is required. You must call Member Services for approval or penalty applies.	Primary care physician must approve hospital stay. \$250 co-pay, 100%
In-Patient Room & Board (Semi-Private)	90% Subject to deductible	80% Subject to deductible	100%	70% Subject to deductible	100%
In-Patient Ancillary Charge	90% Subject to deductible	80% Subject to deductible	100%	70% Subject to deductible	100%
Out-Patient Emergency Hospital Charges	90% Subject to deductible	80% Subject to deductible	\$100 Co-pay, 100% provided you follow the POS emergency procedure described in the POS literature.	If plan's definition of emergency is met then benefit paid at in-network level regardless of provider, otherwise paid at 70% subject to deductible.	\$75 Co-pay, 100% provided you follow HMO emergency procedure described in each HMO literature.
Out-Patient Emergency Doctor Charge	90% Subject to deductible	80% Subject to deductible	100% Provided you follow the POS emergency procedure described in the plan's literature	If plan's definition of emergency is met then benefit paid at in-network level regardless of provider, otherwise paid at 70% subject to deductible.	100% Provided you follow the HMO emergency procedure described in the plan's literature
SURGERY					
In-Patient	90% Subject to deductible	80% Subject to deductible	100%	70% Subject to deductible	100%
Out-Patient	90% Subject to deductible	80% Subject to deductible	\$100 Co-pay, 100%	70% Subject to deductible	\$50 Co-pay, 100%
NEWBORN					
Hospital Nursery	90% Subject to deductible	80% Subject to deductible	100%	70% Subject to deductible	100%
Well Baby Care (Office Visit)	\$20 Co-pay, 100% to age 2	Not Covered	\$20 Co-pay, 100%	Not Covered	\$15 Co-pay, 100%
ROUTINE SERVICES					
Annual Physical Exam	\$20 Co-pay, 100% to \$750	Not Covered	\$20 Co-pay, 100%	Not Covered	\$15 Co-pay, 100%
Immunizations & Inoculations	See Well Baby Care	Not Covered	\$20 Co-pay, 100%	Not Covered	\$15 Co-pay, 100%
Eye Exams	Not Covered	Not Covered	\$10 Co-pay, 100% every 24 months	Not Covered	\$15 Co-pay, 100% every 12 months
Discounts on Glasses	Not Covered	Not Covered	Not Covered	Not Covered	\$75 Allowance every 24 months
Hearing Exams	Not Covered	Not Covered	\$30 Co-pay, 100%	Not Covered	\$15 Co-pay, 100%

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MENTAL HEALTH

Office Visits	\$30 Co-pay, 100%	80% Subject to deductible	\$30 Co-pay	70% subject to deductible	\$25 Co-pay
Hospital In-Patient	90% Subject to deductible	80% Subject to deductible	\$200 Co-pay, 100%	70% Subject to deductible	\$250 Co-pay, 100%
		Precertification required		Precertification required	

SUBSTANCE ABUSE

Hospital In-Patient	90% Subject to deductible	80% Subject to deductible	\$200 Co-pay 100%	70% Subject to deductible	\$250 Co-pay, 100%
		Precertification required		Precertification required	

PRESCRIPTION DRUGS	Generic In-Network	Preferred Brand In-Network	Non-Preferred Brand In-Network	Mail Order (90 Day Supply) In-Network	Out-Of-Network
CIGNA OPEN ACCESS PLUS	\$10 Co-pay	\$20 Co-pay	\$40 Co-pay	\$20 Co-pay (Generic) \$40 Co-pay (Preferred) \$80 Co-pay (Non-Preferred)	80% Subject to the Rx deductible of \$50
CIGNA NETWORK POS	\$10 Co-pay	\$20 Co-pay	\$40 Co-pay	\$20 Co-pay (Generic) \$40 Co-pay (Preferred) \$80 Co-pay (Non-Preferred)	70% Subject to the Rx deductible of \$50
HMO IL	\$10 Co-pay	\$20 Co-pay	\$35 Co-Pay	\$20 Co-pay (Generic) \$40 Co-pay (Preferred) \$70 Co-pay (Non-Preferred)	N/A
BLUE ADVANTAGE HMO	\$10 Co-pay	\$15 Co-pay	\$30 Co-Pay	\$20 Co-pay (Generic) \$30 Co-pay (Preferred) \$60 Co-pay (Non-Preferred)	N/A

EXCLUSIONS AND LIMITATIONS.

All services must be medically necessary and are subject to carrier plan rules and limitations. Consult the CIGNA Group Insurance Certificate and HMO Contracts and/or booklets for specifics.

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